

AMENDED IN ASSEMBLY APRIL 30, 2014

AMENDED IN ASSEMBLY MARCH 28, 2014

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL

No. 2301

Introduced by Assembly Member Mansoor

February 21, 2014

An act to amend Section 100503 of the Government Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2301, as amended, Mansoor. California Health Benefit Exchange: *individual market* reports.

Existing law establishes the California Health Benefit Exchange within state government, specifies the powers and duties of the board governing the Exchange, and requires the board to facilitate the purchase of qualified health plans through the Exchange by qualified individuals and small employers. Existing law requires the board of the Exchange to annually prepare a written report on the implementation and performance of the Exchange functions during the preceding fiscal year, as specified, and requires that this report be submitted to the Legislature and the Governor and be made available to the public on the Internet Web site of the Exchange. Existing law requires the board to require carriers participating in the Exchange to immediately notify the Exchange when an individual is or will be disenrolled from a qualified health plan offered by the carrier.

This bill would also require the board to prepare a written report on a quarterly basis that identifies the number of ~~covered lives under~~ *individuals enrolled in* qualified health plans purchased through the

individual market of the Exchange by ~~specified categories~~ *demographics, level of coverage, and geographic region, and the number of applications filed through the individual market of the Exchange for each quarter, as specified.* The bill would also require this report to identify the number of individuals who have been disenrolled from those plans ~~due to nonpayment of the premiums, as specified~~ *by total number, demographics, level of coverage, geographic region, and reason for disenrollment.* The bill would require this report to be submitted to the Legislature and the Governor and to be made available to the public on the Internet Web site of the Exchange.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

The people of the State of California do enact as follows:

- 1 SECTION 1. Section 100503 of the Government Code, as
2 amended by Section 4 of Chapter 5 of the 1st Extraordinary Session
3 of the Statutes of 2013, is amended to read:
4 100503. In addition to meeting the minimum requirements of
5 Section 1311 of the federal act, the board shall do all of the
6 following:
7 (a) Determine the criteria and process for eligibility, enrollment,
8 and disenrollment of enrollees and potential enrollees in the
9 Exchange and coordinate that process with the state and local
10 government entities administering other health care coverage
11 programs, including the State Department of Health Care Services,
12 the Managed Risk Medical Insurance Board, and California
13 counties, in order to ensure consistent eligibility and enrollment
14 processes and seamless transitions between coverage.
15 (b) Develop processes to coordinate with the county entities
16 that administer eligibility for the Medi-Cal program and the entity
17 that determines eligibility for the Healthy Families Program,
18 including, but not limited to, processes for case transfer, referral,
19 and enrollment in the Exchange of individuals applying for
20 assistance to those entities, if allowed or required by federal law.
21 (c) Determine the minimum requirements a carrier must meet
22 to be considered for participation in the Exchange, and the
23 standards and criteria for selecting qualified health plans to be
24 offered through the Exchange that are in the best interests of
25 qualified individuals and qualified small employers. The board

1 shall consistently and uniformly apply these requirements,
2 standards, and criteria to all carriers. In the course of selectively
3 contracting for health care coverage offered to qualified individuals
4 and qualified small employers through the Exchange, the board
5 shall seek to contract with carriers so as to provide health care
6 coverage choices that offer the optimal combination of choice,
7 value, quality, and service.

8 (d) Provide, in each region of the state, a choice of qualified
9 health plans at each of the five levels of coverage contained in
10 subsections (d) and (e) of Section 1302 of the federal act.

11 (e) Require, as a condition of participation in the Exchange,
12 carriers to fairly and affirmatively offer, market, and sell in the
13 Exchange at least one product within each of the five levels of
14 coverage contained in subsections (d) and (e) of Section 1302 of
15 the federal act. The board may require carriers to offer additional
16 products within each of those five levels of coverage. This
17 subdivision shall not apply to a carrier that solely offers
18 supplemental coverage in the Exchange under paragraph (10) of
19 subdivision (a) of Section 100504.

20 (f) (1) Except as otherwise provided in this section and Section
21 100504.5, require, as a condition of participation in the Exchange,
22 carriers that sell any products outside the Exchange to do both of
23 the following:

24 (A) Fairly and affirmatively offer, market, and sell all products
25 made available to individuals in the Exchange to individuals
26 purchasing coverage outside the Exchange.

27 (B) Fairly and affirmatively offer, market, and sell all products
28 made available to small employers in the Exchange to small
29 employers purchasing coverage outside the Exchange.

30 (2) For purposes of this subdivision, “product” does not include
31 contracts entered into pursuant to Part 6.2 (commencing with
32 Section 12693) of Division 2 of the Insurance Code between the
33 Managed Risk Medical Insurance Board and carriers for enrolled
34 Healthy Families beneficiaries or contracts entered into pursuant
35 to Chapter 7 (commencing with Section 14000) of, or Chapter 8
36 (commencing with Section 14200) of, Part 3 of Division 9 of the
37 Welfare and Institutions Code between the State Department of
38 Health Care Services and carriers for enrolled Medi-Cal
39 beneficiaries. “Product” also does not include a bridge plan product
40 offered pursuant to Section 100504.5.

(3) Except as required by Section 1301(a)(1)(C)(ii) of the federal act, a carrier offering a bridge plan product in the Exchange may limit the products it offers in the Exchange solely to a bridge plan product contract.

(g) Determine when an enrollee's coverage commences and the extent and scope of coverage.

(h) Provide for the processing of applications and the enrollment and disenrollment of enrollees.

(i) Determine and approve cost-sharing provisions for qualified health plans.

(j) Establish uniform billing and payment policies for qualified health plans offered in the Exchange to ensure consistent enrollment and disenrollment activities for individuals enrolled in the Exchange.

(k) Undertake activities necessary to market and publicize the availability of health care coverage and federal subsidies through the Exchange. The board shall also undertake outreach and enrollment activities that seek to assist enrollees and potential enrollees with enrolling and reenrolling in the Exchange in the least burdensome manner, including populations that may experience barriers to enrollment, such as the disabled and those with limited English language proficiency.

(l) Select and set performance standards and compensation for navigators selected under subdivision (l) of Section 100502.

(m) Employ necessary staff.

(1) The board shall hire a chief fiscal officer, a chief operations officer, a director for the SHOP Exchange, a director of Health Plan Contracting, a chief technology and information officer, a general counsel, and other key executive positions, as determined by the board, who shall be exempt from civil service.

(2) (A) The board shall set the salaries for the exempt positions described in paragraph (1) and subdivision (i) of Section 100500 in amounts that are reasonably necessary to attract and retain individuals of superior qualifications. The salaries shall be published by the board in the board's annual budget. The board's annual budget shall be posted on the Internet Web site of the Exchange. To determine the compensation for these positions, the board shall cause to be conducted, through the use of independent outside advisors, salary surveys of both of the following:

1 (i) Other state and federal health insurance exchanges that are
2 most comparable to the Exchange.

3 (ii) Other relevant labor pools.

4 (B) The salaries established by the board under subparagraph
5 (A) shall not exceed the highest comparable salary for a position
6 of that type, as determined by the surveys conducted pursuant to
7 subparagraph (A).

8 (C) The Department of Human Resources shall review the
9 methodology used in the surveys conducted pursuant to
10 subparagraph (A).

11 (3) The positions described in paragraph (1) and subdivision (i)
12 of Section 100500 shall not be subject to otherwise applicable
13 provisions of the Government Code or the Public Contract Code
14 and, for those purposes, the Exchange shall not be considered a
15 state agency or public entity.

16 (n) Assess a charge on the qualified health plans offered by
17 carriers that is reasonable and necessary to support the
18 development, operations, and prudent cash management of the
19 Exchange. This charge shall not affect the requirement under
20 Section 1301 of the federal act that carriers charge the same
21 premium rate for each qualified health plan whether offered inside
22 or outside the Exchange.

23 (o) Authorize expenditures, as necessary, from the California
24 Health Trust Fund to pay program expenses to administer the
25 Exchange.

26 (p) Keep an accurate accounting of all activities, receipts, and
27 expenditures, and annually submit to the United States Secretary
28 of Health and Human Services a report concerning that accounting.
29 Commencing January 1, 2016, the board shall conduct an annual
30 audit.

31 (q) (1) Notwithstanding Section 10231.5, annually prepare a
32 written report on the implementation and performance of the
33 Exchange functions during the preceding fiscal year, including, at
34 a minimum, the manner in which funds were expended and the
35 progress toward, and the achievement of, the requirements of this
36 title. The report shall also include data provided by health care
37 service plans and health insurers offering bridge plan products
38 regarding the extent of health care provider and health facility
39 overlap in their Medi-Cal networks as compared to the health care

1 provider and health facility networks contracting with the plan or
2 insurer in their bridge plan contracts.

3 (2) The Exchange shall prepare, or contract for the preparation
4 of, an evaluation of the bridge plan program using the first three
5 years of experience with the program. The evaluation shall be
6 provided to the health policy and fiscal committees of the
7 Legislature in the fourth year following federal approval of the
8 bridge plan option. The evaluation shall include, but not be limited
9 to, all of the following:

10 (A) The number of individuals eligible to participate in the
11 bridge plan program each year by category of eligibility.

12 (B) The number of eligible individuals who elect a bridge plan
13 option each year by category of eligibility.

14 (C) The average length of time, by region and statewide, that
15 individuals remain in the bridge plan option each year by category
16 of eligibility.

17 (D) The regions of the state with a bridge plan option, and the
18 carriers in each region that offer a bridge plan, by year.

19 (E) The premium difference each year, by region, between the
20 bridge plan and the first and second lowest cost ~~plan~~ *plans* for
21 individuals in the Exchange who are not eligible for the bridge
22 plan.

23 (F) The effect of the bridge plan on the premium subsidy amount
24 for bridge plan eligible individuals each year by each region.

25 (G) Based on a survey of individuals enrolled in the bridge plan:

26 (i) Whether individuals enrolling in the bridge plan product are
27 able to keep their existing health care providers.

28 (ii) Whether individuals would want to retain their bridge plan
29 product, buy a different Exchange product, or decline to purchase
30 health insurance if there was no bridge plan product available. The
31 Exchange may include questions designed to elicit the information
32 in this subparagraph as part of an existing survey of individuals
33 receiving coverage in the Exchange.

34 (3) In addition to the evaluation required by paragraph (2), the
35 Exchange shall post the items in subparagraphs (A) to (F),
36 inclusive, on its Internet Web site each year.

37 (4) (A) In addition to the report described in paragraph (1), and
38 notwithstanding Section 10231.5, the board shall ~~quarterly~~ prepare
39 a written report ~~that identifies the number of covered lives under~~
40 ~~qualified health plans purchased through the individual market of~~

1 ~~the Exchange by the following categories:~~ *on a quarterly basis*
2 *regarding the status of the individual market of the Exchange. The*
3 *report shall be made available, as described in paragraph (5),*
4 *within 30 days following the end of each quarter and shall, at a*
5 *minimum, include all of the following information:*

6 ~~(i) Total number overall.~~

7 ~~(ii) Age.~~

8 ~~(iii) Ethnicity.~~

9 ~~(iv) Gender.~~

10 ~~(v) Income level.~~

11 *(i) Demographic information regarding the number of*
12 *individuals enrolled in qualified health plans purchased through*
13 *the individual market of the Exchange, including, but not limited*
14 *to, gender, age, race, ethnicity, primary language, and income*
15 *level.*

16 *(ii) The number of individuals enrolled in qualified health plans*
17 *purchased through the individual market of the Exchange in each*
18 *of the levels of coverage identified in Section 1367.008 of the*
19 *Health and Safety Code and Section 10112.295 of the Insurance*
20 *Code.*

21 ~~(vi)~~

22 *(iii) The number of individuals enrolled in qualified health plans*
23 *purchased through the individual market of the Exchange in each*
24 *of the geographic regions listed in Section 1357.512 1399.855 of*
25 *the Health and Safety Code and Section 10965.9 of the Insurance*
26 *Code.*

27 *(iv) The number of applications that were filed through the*
28 *individual market of the Exchange since the end of the previous*
29 *quarter.*

30 *(v) The number of applications that were filed through the*
31 *individual market of the Exchange since the end of the previous*
32 *quarter with the help of an agent, a certified enrollment counselor,*
33 *as defined in Section 6650 of Title 10 of the California Code of*
34 *Regulations, or any other person or entity.*

35 *(vi) The number of applications that were filed through the*
36 *individual market of the Exchange using the Internet Web site of*
37 *the Exchange maintained under subdivision (c) of Section 100502.*

38 *(B) The report required by this paragraph shall also identify the*
39 *number of individuals, by the categories listed in subparagraph*
40 *(A), who, since the end of the last previous quarter, or since January*

1 1, 2014, in the case of the first report, have been disenrolled from
2 a qualified health plan purchased through the individual market
3 of the Exchange ~~due to nonpayment of the premiums by the~~
4 *following categories:*

5 ~~(C) The report required by this paragraph shall be completed~~
6 ~~within 30 days of the end of a quarter.~~

7 *(i) Total number.*

8 *(ii) Demographics, including, but not limited to, gender, age,*
9 *race, ethnicity, primary language, and income level.*

10 *(iii) The levels of coverage described in Section 1367.008 of*
11 *the Health and Safety Code and Section 10112.295 of the Insurance*
12 *Code.*

13 *(iv) The geographic regions listed in Section 1399.855 of the*
14 *Health and Safety Code and Section 10965.9 of the Insurance*
15 *Code.*

16 *(v) Reasons for disenrollment.*

17 (5) The reports required by this subdivision shall be transmitted
18 to the Legislature and the Governor and shall be made available
19 to the public on the Internet Web site of the Exchange. The reports
20 made to the Legislature pursuant to this subdivision shall be
21 submitted pursuant to Section 9795.

22 (6) In addition to the reports described in ~~paragraphs (1) and~~
23 ~~(2)~~ *this subdivision*, the board shall be responsive to requests for
24 additional information from the Legislature, including providing
25 testimony and commenting on proposed state legislation or policy
26 issues. The Legislature finds and declares that activities, including,
27 but not limited to, responding to legislative or executive inquiries,
28 tracking and commenting on legislation and regulatory activities,
29 and preparing reports on the implementation of this title and the
30 performance of the Exchange, are necessary state requirements
31 and are distinct from the promotion of legislative or regulatory
32 modifications referred to in subdivision (d) of Section 100520.

33 (r) Maintain enrollment and expenditures to ensure that
34 expenditures do not exceed the amount of revenue in the fund, and
35 if sufficient revenue is not available to pay estimated expenditures,
36 institute appropriate measures to ensure fiscal solvency.

37 (s) Exercise all powers reasonably necessary to carry out and
38 comply with the duties, responsibilities, and requirements of this
39 act and the federal act.

1 (t) Consult with stakeholders relevant to carrying out the
2 activities under this title, including, but not limited to, all of the
3 following:

4 (1) Health care consumers who are enrolled in health plans.

5 (2) Individuals and entities with experience in facilitating
6 enrollment in health plans.

7 (3) Representatives of small businesses and self-employed
8 individuals.

9 (4) The State Medi-Cal Director.

10 (5) Advocates for enrolling hard-to-reach populations.

11 (u) Facilitate the purchase of qualified health plans in the
12 Exchange by qualified individuals and qualified small employers
13 no later than January 1, 2014.

14 (v) Report, or contract with an independent entity to report, to
15 the Legislature by December 1, 2018, on whether to adopt the
16 option in Section 1312(c)(3) of the federal act to merge the
17 individual and small employer markets. In its report, the board
18 shall provide information, based on at least two years of data from
19 the Exchange, on the potential impact on rates paid by individuals
20 and by small employers in a merged individual and small employer
21 market, as compared to the rates paid by individuals and small
22 employers if a separate individual and small employer market is
23 maintained. A report made pursuant to this subdivision shall be
24 submitted pursuant to Section 9795.

25 (w) With respect to the SHOP Program, collect premiums and
26 administer all other necessary and related tasks, including, but not
27 limited to, enrollment and plan payment, in order to make the
28 offering of employee plan choice as simple as possible for qualified
29 small employers.

30 (x) Require carriers participating in the Exchange to immediately
31 notify the Exchange, under the terms and conditions established
32 by the board when an individual is or will be enrolled in or
33 disenrolled from any qualified health plan offered by the carrier.

34 (y) Ensure that the Exchange provides oral interpretation
35 services in any language for individuals seeking coverage through
36 the Exchange and makes available a toll-free telephone number
37 for the hearing and speech impaired. The board shall ensure that
38 written information made available by the Exchange is presented
39 in a plainly worded, easily understandable format and made
40 available in prevalent languages.

(z) This section shall become inoperative on the October 1 that is five years after the date that federal approval of the bridge plan option occurs, and, as of the second January 1 thereafter, is repealed, unless a later enacted statute that is enacted before that date deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 2. Section 100503 of the Government Code, as added by Section 5 of Chapter 5 of the 1st Extraordinary Session of the Statutes of 2013, is amended to read:

100503. In addition to meeting the minimum requirements of Section 1311 of the federal act, the board shall do all of the following:

(a) Determine the criteria and process for eligibility, enrollment, and disenrollment of enrollees and potential enrollees in the Exchange and coordinate that process with the state and local government entities administering other health care coverage programs, including the State Department of Health Care Services, the Managed Risk Medical Insurance Board, and California counties, in order to ensure consistent eligibility and enrollment processes and seamless transitions between coverage.

(b) Develop processes to coordinate with the county entities that administer eligibility for the Medi-Cal program and the entity that determines eligibility for the Healthy Families Program, including, but not limited to, processes for case transfer, referral, and enrollment in the Exchange of individuals applying for assistance to those entities, if allowed or required by federal law.

(c) Determine the minimum requirements a carrier must meet to be considered for participation in the Exchange, and the standards and criteria for selecting qualified health plans to be offered through the Exchange that are in the best interests of qualified individuals and qualified small employers. The board shall consistently and uniformly apply these requirements, standards, and criteria to all carriers. In the course of selectively contracting for health care coverage offered to qualified individuals and qualified small employers through the Exchange, the board shall seek to contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service.

1 (d) Provide, in each region of the state, a choice of qualified
2 health plans at each of the five levels of coverage contained in
3 subsections (d) and (e) of Section 1302 of the federal act.

4 (e) Require, as a condition of participation in the Exchange,
5 carriers to fairly and affirmatively offer, market, and sell in the
6 Exchange at least one product within each of the five levels of
7 coverage contained in subsections (d) and (e) of Section 1302 of
8 the federal act. The board may require carriers to offer additional
9 products within each of those five levels of coverage. This
10 subdivision shall not apply to a carrier that solely offers
11 supplemental coverage in the Exchange under paragraph (10) of
12 subdivision (a) of Section 100504.

13 (f) (1) Require, as a condition of participation in the Exchange,
14 carriers that sell any products outside the Exchange to do both of
15 the following:

16 (A) Fairly and affirmatively offer, market, and sell all products
17 made available to individuals in the Exchange to individuals
18 purchasing coverage outside the Exchange.

19 (B) Fairly and affirmatively offer, market, and sell all products
20 made available to small employers in the Exchange to small
21 employers purchasing coverage outside the Exchange.

22 (2) For purposes of this subdivision, “product” does not include
23 contracts entered into pursuant to Part 6.2 (commencing with
24 Section 12693) of Division 2 of the Insurance Code between the
25 Managed Risk Medical Insurance Board and carriers for enrolled
26 Healthy Families beneficiaries or contracts entered into pursuant
27 to Chapter 7 (commencing with Section 14000) of, or Chapter 8
28 (commencing with Section 14200) of, Part 3 of Division 9 of the
29 Welfare and Institutions Code between the State Department of
30 Health Care Services and carriers for enrolled Medi-Cal
31 beneficiaries.

32 (g) Determine when an enrollee’s coverage commences and the
33 extent and scope of coverage.

34 (h) Provide for the processing of applications and the enrollment
35 and disenrollment of enrollees.

36 (i) Determine and approve cost-sharing provisions for qualified
37 health plans.

38 (j) Establish uniform billing and payment policies for qualified
39 health plans offered in the Exchange to ensure consistent

1 enrollment and disenrollment activities for individuals enrolled in
2 the Exchange.

3 (k) Undertake activities necessary to market and publicize the
4 availability of health care coverage and federal subsidies through
5 the Exchange. The board shall also undertake outreach and
6 enrollment activities that seek to assist enrollees and potential
7 enrollees with enrolling and reenrolling in the Exchange in the
8 least burdensome manner, including populations that may
9 experience barriers to enrollment, such as the disabled and those
10 with limited English language proficiency.

11 (l) Select and set performance standards and compensation for
12 navigators selected under subdivision (l) of Section 100502.

13 (m) Employ necessary staff.

14 (1) The board shall hire a chief fiscal officer, a chief operations
15 officer, a director for the SHOP Exchange, a director of Health
16 Plan Contracting, a chief technology and information officer, a
17 general counsel, and other key executive positions, as determined
18 by the board, who shall be exempt from civil service.

19 (2) (A) The board shall set the salaries for the exempt positions
20 described in paragraph (1) and subdivision (i) of Section 100500
21 in amounts that are reasonably necessary to attract and retain
22 individuals of superior qualifications. The salaries shall be
23 published by the board in the board's annual budget. The board's
24 annual budget shall be posted on the Internet Web site of the
25 Exchange. To determine the compensation for these positions, the
26 board shall cause to be conducted, through the use of independent
27 outside advisors, salary surveys of both of the following:

28 (i) Other state and federal health insurance exchanges that are
29 most comparable to the Exchange.

30 (ii) Other relevant labor pools.

31 (B) The salaries established by the board under subparagraph
32 (A) shall not exceed the highest comparable salary for a position
33 of that type, as determined by the surveys conducted pursuant to
34 subparagraph (A).

35 (C) The Department of Human Resources shall review the
36 methodology used in the surveys conducted pursuant to
37 subparagraph (A).

38 (3) The positions described in paragraph (1) and subdivision (i)
39 of Section 100500 shall not be subject to otherwise applicable
40 provisions of the Government Code or the Public Contract Code

1 and, for those purposes, the Exchange shall not be considered a
2 state agency or public entity.

3 (n) Assess a charge on the qualified health plans offered by
4 carriers that is reasonable and necessary to support the
5 development, operations, and prudent cash management of the
6 Exchange. This charge shall not affect the requirement under
7 Section 1301 of the federal act that carriers charge the same
8 premium rate for each qualified health plan whether offered inside
9 or outside the Exchange.

10 (o) Authorize expenditures, as necessary, from the California
11 Health Trust Fund to pay program expenses to administer the
12 Exchange.

13 (p) Keep an accurate accounting of all activities, receipts, and
14 expenditures, and annually submit to the United States Secretary
15 of Health and Human Services a report concerning that accounting.
16 Commencing January 1, 2016, the board shall conduct an annual
17 audit.

18 (q) (1) Notwithstanding Section 10231.5, annually prepare a
19 written report on the implementation and performance of the
20 Exchange functions during the preceding fiscal year, including, at
21 a minimum, the manner in which funds were expended and the
22 progress toward, and the achievement of, the requirements of this
23 title.

24 (2) (A) In addition to the report described in paragraph (1), and
25 notwithstanding Section 10231.5, the board shall ~~quarterly~~ prepare
26 a written report ~~that identifies the number of covered lives under~~
27 ~~qualified health plans purchased through the individual market of~~
28 ~~the Exchange by the following categories:~~ *on a quarterly basis*
29 *regarding the status of the individual market of the Exchange. The*
30 *report shall be made available, as described in paragraph (3),*
31 *within 30 days following the end of each quarter and shall, at a*
32 *minimum, include all of the following information:*

33 ~~(i) Total number overall.~~

34 ~~(ii) Age.~~

35 ~~(iii) Ethnicity.~~

36 ~~(iv) Gender.~~

37 ~~(v) Income level.~~

38 *(i) Demographic information regarding the number of*
39 *individuals enrolled in qualified health plans purchased through*
40 *the individual market of the Exchange, including, but not limited*

1 *to, gender, age, race, ethnicity, primary language, and income*
2 *level.*

3 *(ii) The number of individuals enrolled in qualified health plans*
4 *purchased through the individual market of the Exchange in each*
5 *of the levels of coverage identified in Section 1367.008 of the*
6 *Health and Safety Code and Section 10112.295 of the Insurance*
7 *Code.*

8 ~~*(vi)*~~

9 *(iii) The number of individuals enrolled in qualified health plans*
10 *purchased through the individual market of the Exchange in each*
11 *of the geographic regions listed in Section 1357.512 1399.855 of*
12 *the Health and Safety Code and Section 10965.9 of the Insurance*
13 *Code.*

14 *(iv) The number of applications that were filed through the*
15 *individual market of the Exchange since the end of the previous*
16 *quarter.*

17 *(v) The number of applications that were filed through the*
18 *individual market of the Exchange since the end of the previous*
19 *quarter with the help of an agent, a certified enrollment counselor,*
20 *as defined in Section 6650 of Title 10 of the California Code of*
21 *Regulations, or any other person or entity.*

22 *(vi) The number of applications that were filed through the*
23 *individual market of the Exchange using the Internet Web site of*
24 *the Exchange maintained under subdivision (c) of Section 100502.*

25 *(B) The report required by this paragraph shall also identify the*
26 *number of individuals, by the categories listed in subparagraph*
27 ~~*(A),*~~ *who, since the end of the last previous quarter, or since January*
28 *1, 2014, in the case of the first report, have been disenrolled from*
29 *a qualified health plan purchased through the individual market*
30 *of the Exchange was canceled due to nonpayment of the premiums.*
31 *by the following categories:*

32 ~~*(C) The report required by this paragraph shall be completed*~~
33 ~~*within 30 days of the end of each quarter.*~~

34 *(i) Total number.*

35 *(ii) Demographics, including, but not limited to, gender, age,*
36 *race, ethnicity, primary language, and income level.*

37 *(iii) The levels of coverage described in Section 1367.008 of*
38 *the Health and Safety Code and Section 10112.295 of the Insurance*
39 *Code.*

1 (iv) *The geographic regions listed in Section 1399.855 of the*
2 *Health and Safety Code and Section 10965.9 of the Insurance*
3 *Code.*

4 (v) *Reasons for disenrollment.*

5 (3) The reports required by this subdivision shall be transmitted
6 to the Legislature and the Governor and shall be made available
7 to the public on the Internet Web site of the Exchange. The reports
8 made to the Legislature pursuant to this subdivision shall be
9 submitted pursuant to Section 9795.

10 (4) In addition to the reports described in paragraphs (1) and
11 (2), the board shall be responsive to requests for additional
12 information from the Legislature, including providing testimony
13 and commenting on proposed state legislation or policy issues.
14 The Legislature finds and declares that activities, including, but
15 not limited to, responding to legislative or executive inquiries,
16 tracking and commenting on legislation and regulatory activities,
17 and preparing reports on the implementation of this title and the
18 performance of the Exchange, are necessary state requirements
19 and are distinct from the promotion of legislative or regulatory
20 modifications referred to in subdivision (d) of Section 100520.

21 (r) Maintain enrollment and expenditures to ensure that
22 expenditures do not exceed the amount of revenue in the fund, and
23 if sufficient revenue is not available to pay estimated expenditures,
24 institute appropriate measures to ensure fiscal solvency.

25 (s) Exercise all powers reasonably necessary to carry out and
26 comply with the duties, responsibilities, and requirements of this
27 act and the federal act.

28 (t) Consult with stakeholders relevant to carrying out the
29 activities under this title, including, but not limited to, all of the
30 following:

31 (1) Health care consumers who are enrolled in health plans.

32 (2) Individuals and entities with experience in facilitating
33 enrollment in health plans.

34 (3) Representatives of small businesses and self-employed
35 individuals.

36 (4) The State Medi-Cal Director.

37 (5) Advocates for enrolling hard-to-reach populations.

38 (u) Facilitate the purchase of qualified health plans in the
39 Exchange by qualified individuals and qualified small employers
40 no later than January 1, 2014.

(v) Report, or contract with an independent entity to report, to the Legislature by December 1, 2018, on whether to adopt the option in Section 1312(c)(3) of the federal act to merge the individual and small employer markets. In its report, the board shall provide information, based on at least two years of data from the Exchange, on the potential impact on rates paid by individuals and by small employers in a merged individual and small employer market, as compared to the rates paid by individuals and small employers if a separate individual and small employer market is maintained. A report made pursuant to this subdivision shall be submitted pursuant to Section 9795.

(w) With respect to the SHOP Program, collect premiums and administer all other necessary and related tasks, including, but not limited to, enrollment and plan payment, in order to make the offering of employee plan choice as simple as possible for qualified small employers.

(x) Require carriers participating in the Exchange to immediately notify the Exchange, under the terms and conditions established by the board, when an individual is or will be enrolled in or disenrolled from any qualified health plan offered by the carrier.

(y) Ensure that the Exchange provides oral interpretation services in any language for individuals seeking coverage through the Exchange and makes available a toll-free telephone number for the hearing and speech impaired. The board shall ensure that written information made available by the Exchange is presented in a plainly worded, easily understandable format and made available in prevalent languages.

(z) This section shall become operative only if Section 4 of the act that added this section becomes inoperative pursuant to subdivision (z) of that Section 4.